STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155519	A. BUILDING 00 B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GENTLE CARE STRATEGIES	1202 S 16TH ST VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00444101. Complaint IN00444101: - Federal/State deficiencies related to the allegations are cited at F689. Survey date: September 30, 2024 Facility number: 000357 Provider number: 155519 AIM number: 100291370 Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 7 Medicaid: 32 Other: 9 Total: 48 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/04/2024 to the state findings of the recent complaint investigation. We are requesting paper compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a secured environment was in place to prevent a resident with dementia from exiting the facility unsupervised. On 9/21/24, while on 15-minute checks, a resident was noticed to be missing at 5:20 A.M. Staff quickly located the	F 0689	It is the practice of this facility to ensure adequate supervision and a seccure environment. 1. What corrective actions will be accomplished for those residents found to be affected by the	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Sluder	Administrator	10/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident outside the Hall 2 emergency exit door where the resident exited the facility and apparently fallen while unsupervised. (Resident C) Finding includes: A review of facility reported incidents on 9/30/24 at 11:15 A.M., included an IDOH (Indiana Department of Health) Reportable Incident form completed by the Facility Administrator, with an incident date of 9/21/24 at 5:30 A.M., indicated that staff was notified that Resident C was missing from her room at approximately 5:20 A.M. Staff went to the Hall 2 exit door and found Resident C sitting on the ground outside of the facility. Resident C was noted to have a small abrasion on her palms with a scant amount of fresh blood around left temple area. Resident was assessed and assisted back into the facility at approximately 5:30 A.M. On 9/30/24 at 11:20 A.M., LPN 4 indicated that Resident C was at risk for wandering and elopement and wore a WanderGaurd bracelet (a device that triggers door alarms and locks monitored doors to prevent the resident from leaving unattended). Resident C was on one-to-one observation at that time due to exit seeking behaviors. During an observation on 9/30/24 at 11:25 A.M. Resident C was sitting in her room with a staff member sitting next to her. The emergency exit door on Hall 2 was observed to have a magnetic alarm attached to it that would sound if the door were opened. During record review on 9/30/24 at 11:30 A.M., Resident C's diagnoses included, but were not limited to vascular dementia with behavioral		deficient practice: a. Resident C was discharged to secured memory care unit on 10/04/2024. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents who have the potential to be affected by the alleged deficiency. b. A review of residents that have been identified for wandering have been reviewed and have safety monitoring in place and documented. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The nursing staff have been in-serviced on 09/30/2024 regarding wander/exit seeking behaviors; reporting exit seeking behaviors; and witness vs unwitnessed incidents. b. Forms implemented for documentation of 15 min checks, 30 min checks, and 2 hour checks for safety. c. Social Service and/or Designee will review during clinical the Social Service alert form for identified behavioral issues. Care plans, behavioral mangement plans, and orders will be updated as needed.	

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	disturbance, unsteadiness on feet, altered mental status, and auditory hallucinations. Resident C's most recent Admission Minimum Data Set (MDS) assessment, dated 9/14/24, indicated the resident had severe cognitive impairment, had no functional impairments to extremities, used a walker for ambulation, could walk 10 feet with supervision of one staff, wandered daily, and that the resident's wandering behavior put the resident at significant risk of getting to a dangerous place (including outside of the facility). Resident C's comprehensive care plan included, but was not limited to: A focus of resident is at risk for elopement due to attempting to exit seek upon admission and wandering at previous facility (initiated 9/14/24) with interventions that included, check function of WanderGaurd every shift, respect resident's right to make decisions, and WanderGaurd placement on resident's wrist at all times. A focus of resident is at risk for wandering and elopement (initiated 9/14/24) with a goal of resident will not leave facility unattended. Resident C's elopement risk evaluation, dated 9/14/23, indicated Resident C had a history of elopement or an attempted elopement while at home and wandered aimlessly. Resident C's physician orders included, but were not limited to, WanderGaurd bracelet with an order date of 9/5/24, and 1:1 supervision to ensure safety with an order date of 9/21/24. Resident C's nurse's progress notes included, but were not limited to the following: On 9/9/24 at 5:55 P.M. - Resident had multiple		d. The Director of Nursing and/or Designee will review during clinical for the completion of these forms. If any discrepancies are identified, then immediate action will be taken. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. A performance improvement tool has been initiated to ensure safety forms are completed and documented on 2 random residents for 5 times per week for the next 4 weeks, then 2 times per week for the next 4 weeks, then 1 time per week for the next quarter. This will continue until substantial compliance is obtained. The outcomes will be reviewed through the facility Quality Assurance Program Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	attempts to exit seek today. WanderGaurd in place and functioning properly. On 9/15/24 at 3:50 P.M. - staff notified nurse that resident had been exit seeking. Thirty (30) minute safety checks changed to 15-minute safety checks. Physician, Administrator, and Direct of Nursing (DON) notified. 9/21/24 at 5:30 A.M. - Incident occurred when resident opened emergency exit door and stepped outside. As resident was going outside, she stepped down and lost balance causing her to scrape body against the brick on the outside of the facility. Resident has abrasions on her arms and on to her face. Resident redirected back inside facility. Administrator, DON, and family notified. A review of the facility's investigation of Resident C's elopement on 9/21/24 included a typed note dated 9/25/24, and signed by RN 6. The note indicated, on 9/21/24 RN 6 was alerted by LPN 9 that at approximately 5:20 A.M., that she needed assistance locating Resident C. LPN 9 indicated that Resident C had been exit-seeking earlier in the night on Hall 2. RN 6 immediately check outside the emergency exit door located on Hall 2 and found Resident C sitting on the ground outside of the facility. Resident C was noted to have a small abrasions on palms and scant amount of fresh blood on left temple area. Resident C was assisted back into the building at approximately 5:30 A.M. LPN 9 indicated that Resident C had been exit-seeking at around 2:00 A.M. but that staff was able to redirect resident back to room and that no administrative staff was notified of the behavior. CNA on hall indicated the last bed check was completed at 5:15 A.M. During an interview on 9/30/24 at 11:45 A.M., the Facility Administrator indicated that Resident C had been on 15 minute safety checks the morning			

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	of 9/21/24 and that the 15 minute checks were documented in the Point of Care (POC) charting system. A review of Resident C's 15-minute safety checks on 9/30/24 at 11:50 A.M., indicated the resident had been 15-minute safety checks the morning of 9/21/24. Documented 15-minute checks included the following times: 9/21/24 - 12:01 A.M. 9/21/24 - 1:09 A.M. 9/21/24 - 3:23 A.M. 9/21/24 - 3:29 A.M. 9/21/24 - 3:32 A.M. 9/21/24 - 3:33 A.M. 9/21/24 - 4:23 A.M. (last documented 15-minute check observation of resident before missing at 5:20 A.M.) During an interview on 9/30/24 at 1:10 P.M., the DON indicated after reviewing the incident and interviewing staff who were on duty the morning of 9/21/24, she did not believe the emergency exit door had alarmed as it should have when pushed open by Resident C when she was able to exit the facility unsupervised. It was not clear as to why the alarm did not sound as it was functioning correctly when all doors were checked following Resident C's elopement. Staff had not indicated that the alarm alerted them that Resident C had exited the door, rather LPN 9 realized Resident C was not in her room at 5:20 A.M. The DON also indicated that if LPN 9 had notified other staff of Resident C's exit seeking behavior on 9/21/24 at 2:00 A.M., an intervention of placing the resident on 1:1 observation could have been implemented. The DON also indicated that an additional alarming device was added the the emergency exit door on Hall 2.			

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	A review of daily door checks on 9/30/24 at 1:25 P.M., indicated all doors had been check the day prior to Resident C's elopement and all door alarms were functioning correctly. On 9/30/24 at 2:20 P.M., the DON supplied a facility policy titled Elopement/Wander Risk Policy, dated 07/2023. The policy included, "...3. Staff members are asked to notify the nurse on duty of any Resident that is suspected of being an elopement risk or found trying to leave the building.... 5. ...All fire doors are equipped with an alarming mechanism regardless of wander-guard in place to alarm staff when a resident is attempting to go out the fire doors..." This citation relates to Complaint IN00444101. 3.1-45(a)(2)			